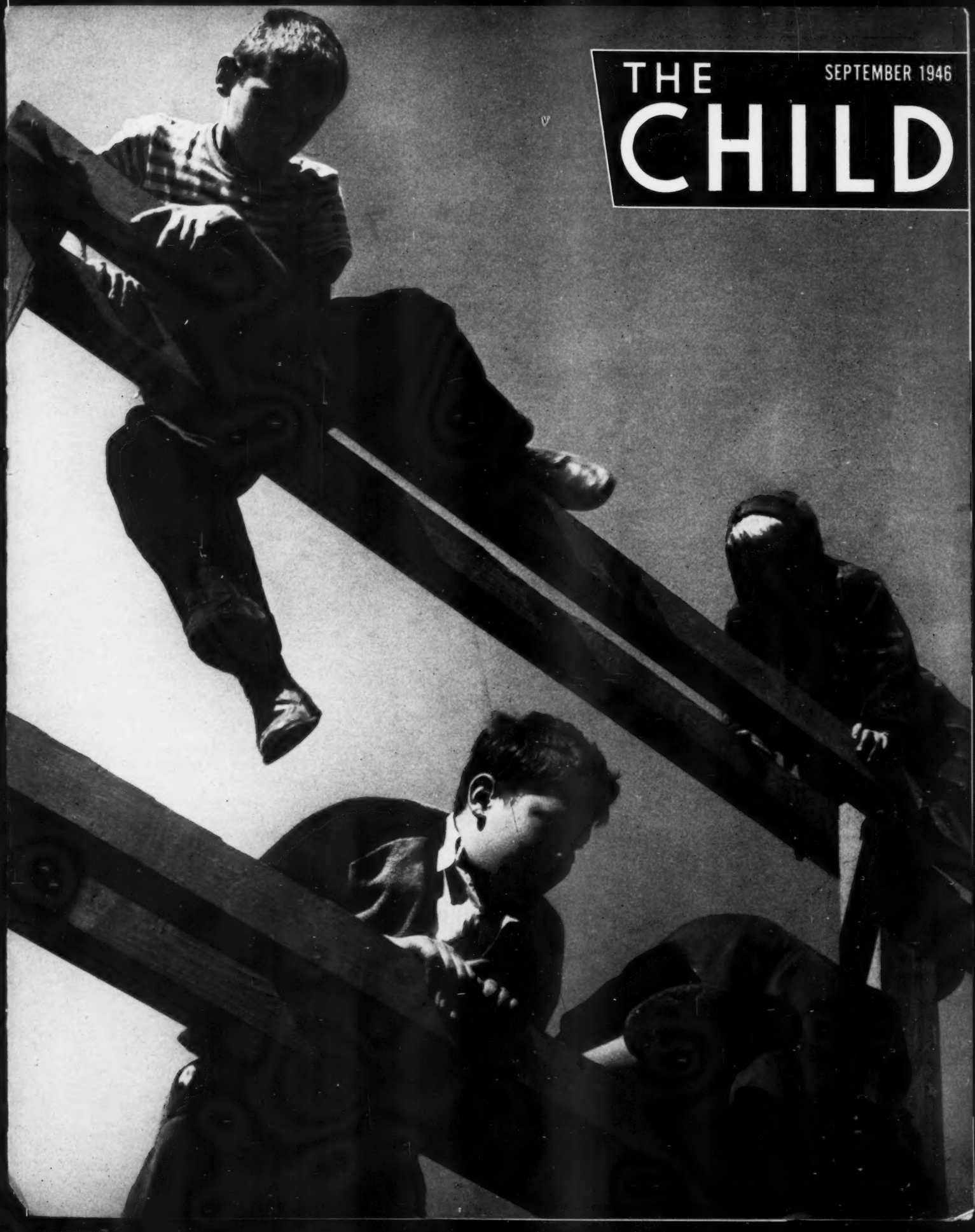

THE CHILD

SEPTEMBER 1946

MENTAL-HEALTH SERVICES IN THE HEALTH-DEPARTMENT PROGRAM

KENT A. ZIMMERMAN, M. D., *Director, Mental Health Unit, U. S. Children's Bureau*

WITHIN the past decade statistical studies have brought out more clearly what we of the medical profession have suspected all along—that mental illness is a very prevalent disease. For example, one of these studies predicts that out of every 20 babies, one will spend some part of his life in a mental hospital.

That fact becomes alive and vivid if one imagines himself a teacher of a classroom of 40 pupils and realizes that the chances are that 2 pupils in that class will develop a serious emotional illness.

Few diseases, other than the common contagious diseases, affect such large numbers of people. And it has only recently been recognized that the distribution of mental illness in a community seems to have epidemic characteristics that are similar in a number of ways to those of contagious diseases.

We people of this country have done much to prevent other epidemic diseases. As individuals and communities, we agree to spend large sums of money for their prevention. We have not been willing to do as much to prevent mental illness. But whether we know it or not, each year we pay huge sums as taxes for the care of the full-blown mental illnesses of our neighbors.

Failure to do more to prevent mental illness does not rest entirely with us as individuals. Perhaps none of us is quite sure how best to spend money for prevention of mental illness. Perhaps we need to be shown that there are methods that we can understand and practice to prevent this kind of illness. Perhaps leaders and teachers in the field of mental disease have not been too specific as to what we should do. Without doubt, in many instances what they have recommended has been stubbornly resisted and is still being resisted.

The cry in the medical profession today is: "Where are the psychiatrists? Give us more psychiatrists so that we can begin to solve this problem."

True, we need thousands of doctors trained in this specialty. The National Committee on Mental Hygiene conservatively estimates that we need 10,000 additional psychiatrists. But even though the psychiatrist is a key person in the situation, he does not have the complete answer. And the profession of psychiatry is risking its neck if it lets the people it serves sell it the bill of goods that psychiatry has all the answers.

We won't have 10,000 additional psychiatrists in 10 years—probably not in 15 years. Meanwhile we can't wait for them. Other professional workers—who haven't been trained in psychiatry—must realize that they can fill important posts in the battle to prevent mental illness. These workers—the doctor in his office or the clinic, the nurse in the home or the hospital, the social worker in the public or private agency—can do their share in preventing mental illness as part of their daily dealings with the people they serve. Especially are the workers of the health department of the State, county, and community in a position to do this.

We repeat childhood patterns

It is a fact accepted by those familiar with human behavior that the way adolescents and adults meet their problems of emotional adjustment seems to repeat the pattern of adjustment they followed during early childhood. General experience shows that efforts to prevent later mental illness are most effective when applied in this early period. This does not mean that efforts applied at later times in the person's growth are not effective. They are, as anyone who works with people knows.

There are two services that reach practically all children of the community. These are the school and the health services. A health department that is responsible for the school health program can influence in some ways the life of almost every child in the community.

What are the services in a health department dealing with medical problems where mental-health problems might also be treated? Certainly the first one we think of is the well-baby clinic, or the child-health conference, as it is often called. In the well-baby clinic one meets problems of feeding, sleeping, and discipline and the like, which usually involve emotional as well as physical troubles.

Crises mark personality

Every child in his normal growth and development has to adjust to what are, for him, major emotional crises. These are, in general, weaning from the breast or bottle, toilet training, the arrival of a new baby in the family, and the beginning of school. Whether the adjustment is difficult or smooth, each of these crises will leave its mark on his growing personality.

It is about such problems that parents most often want to ask the most questions of the doctor, the nurse, and the social worker, and most often go away least satisfied.

When I was on the staff of a pediatric clinic I was impressed with how seldom mothers asked the doctors about toilet training. I talked with some mothers and learned that they felt the doctors couldn't help them much in this. The advice given by different doctors was often contradictory. Sometimes replies were curt. Frequently mothers were given the impression that it is not to a doctor that she should go for such advice.

"So," as one mother said, "I had to ask my mother and my next-door neighbor what to do."

Parents are constantly seeking such information and it is the seeking for this help that frequently reveals friction in

the relationship of the child and parent. This parent-child conflict is most commonly expressed as a complaint by the parent about the child. One mother told me: "I just can't understand what has come over Johnny. He seems to fight me every time I suggest that he eat all the food he has on his plate. Doctor, do you think that I am losing control of him?"

I might say that there is not a mother or a child who doesn't experience this friction, for it is inherent in the very nature of growing up that the child will object to parents' interpreting and imposing upon him the behavior characteristics of the culture in which they live.

Take thumb sucking for an example. It is pretty well accepted that thumb sucking before the appearance of the second teeth does no permanent harm to jaws or teeth. With the current tendency for early bottle feeding, and training in the use of the cup, most babies will do some sucking other than at feedings simply because they have a need to suck that must be fulfilled. Yet granting the existence of this natural urge and its need for satisfaction, most mothers and many doctors feel guilty if a child sucks his thumb. This is understandable because the social code under which we all live says that thumb sucking should be taboo. Poor parent-child relationship may arise from a problem such as this. I have seen a doctor make a mother feel so guilty about her child's thumb sucking that she began to form a resentment toward her child, because after that she felt that the child represented an inadequacy or failure on her part as a mother. The staff of a well-baby clinic

One fertile but neglected field for the promotion of mental health is the prenatal clinic.

Simple psychotherapy can help in many a problem met at a child-health conference.

Health examinations of school children are an opportunity for routine mental-health servce.

Adolescents with venereal infection, troubled by guilt and fear, need sensitive help

should make efforts to guard against such situations so that a mother is not burdened with feelings of guilt and inferiority caused by fear that she isn't being the mother that she wants the neighbors and her husband to think she is.

The prenatal clinic is another fertile but neglected field for prevention of behavior disorders and the promotion of mental health. Pregnancy in any woman brings with it emotions of varying degree and kind—joy, satisfaction, well-being, physical misery, resentment, courage, and feelings that can't be put into words. The pregnant woman has fears and hopes not only about herself, but about her unborn child. These feelings often have a tremendous effect on her relationship to her child after he is born.

One mother, a fairly typical one, told me during the course of a routine well-baby check-up of her concern for her 2-year-old baby boy. An older brother of this woman had spent some time in a mental hospital and she feared that her baby might have in him the seed of mental illness. She had had this fear from the time she knew she was going to have a baby. It had tortured her through her period of pregnancy and she had been unable to throw it off after the child was born. As the baby grew, she began to watch his behavior intently. Every act of his that differed from what she had read about in well-baby books she saw as proof of what she feared. Even the normal resistance to her guidance that the ordinary child of his age shows disturbed her. The more he resisted her, the more fearful she became.

On several visits we discussed her brother's mental illness—its causes and the fact that it was of a nonheredity nature. These talks were very reassuring to her. But she was comforted more by learning that her son's behavior was normal for his age and that her fears had made his actions more difficult for her to deal with.

Think what a great comfort it would have been if this woman could have discussed her fears at the time they began troubling her and how much easier it would have been for her child.

Especially does a pregnant woman feel a need to talk about her fears—to be assured by some one she has confidence in. But most of the time she feels herself at a loss because she finds no professional person who will really listen to her or take her worries seriously.

Many obstetricians fail to recognize that the well-being of the pregnant woman is greatly helped if she can discuss anything she has on her mind. During the prenatal period the health-department doctors and, especially, the nurses of the prenatal clinic have a more than casual opportunity to practice simple psychotherapy. At that time the most elementary procedures can give the richest returns.

The well-baby clinic and the prenatal clinic are only two examples where such psychotherapy can be a part of routine service to patients. Others are the health examinations of school children, sex-education lectures to high-school students, and the premarital examinations that many health departments make.

Sensitive help needed

And there are still other areas of public health where preventive mental hygiene needs to become a part of treatment. Venereal-disease clinics offer a tremendous field. Adolescents with an initial venereal infection, who are troubled by guilt and by fear of the outcome of the disease, need sensitive help. A worker doesn't have to have psychiatric training to give this. What is needed is an inclination to give this help and a mature interest in people—plus a knowledge of proper methods of counseling that would prevent the worker from emotionally upsetting the patient all the more. Given the right kind of supervision and guidance, the doctor and nurse and social worker at these clinics—if not too overworked—should be able to do this if they want to.

The tuberculosis division of the health department has responsibility for the care of a physical disease that often carries with it deep emotional illness. Because of the chronic nature of tuberculosis, the forced isolation of the patient from family, friends, and community, his worries about the job and family support, it is no wonder that depressions and anxiety states frequently accompany this infection. Also in many public-health departments unsympathetic handling of case finding and of X-ray checking after tuberculosis is cured often keep raw old psychological wounds. If wisely done, however, check-ups can be of tremendous psychological benefit. Workers in this field can grow to be more and more sensitive to the early signs of fear, worry, or chronic anxiety in the tuberculous patient. Often a few minutes' conversation with an understanding worker can reduce the resentment against what the patient feels is his fate. Quicker recovery follows and fears of recurrence of the infection are eased.

Changes come through struggle

How can doctors and nurses and social workers be taught this added method of treatment? Certainly lectures alone aren't the answer. Hundreds of nurses, social workers, and doctors have taken courses in child behavior and human psychology. Often from these courses they bring back to their daily practice nothing more than a new set of diagnostic terms—terms that represent no deep understanding of human beings.

Usually changes in a health or welfare worker's way of giving service come through struggle with the actual handling of the personalities involved in the medical and family problem. Frequently long years are necessary to gain from such struggles that unique ability and understanding that enables him to help emotionally the person who is sick. However, we all know that good teachers can help the worker to acquire that ability more speedily. The value of the good nursing or social-work supervisor, and of the effective clinical teacher in the medical school, lies in his being able to teach his students a way of dealing with not only the illness but the patient with the illness as well. It seems to me that this same teaching principle should hold true in the various services given by the health department.

A few health departments are attempting to put such a plan of teaching into practice by having a child psychiatrist take part in the child-health conference. Sometimes a psychiatric social worker goes with the public-health nurse on visits to the homes. The results are heartening. The staff per-

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TRENDS IN DAY CARE

ALICE T. DASHIELL, Field Secretary Child Welfare League of America

WE HAVE NOT yet seen the ultimate results of all the wartime work and planning that American communities did to provide day-care services for children of working mothers. But it is certain that gains in the field of day-care have been made and that we have learned certain valuable lessons in the process of organizing the services.

First of all, we have learned much about community planning, with implications for other child-care programs as well as for day time care. There is no doubt that on the child-care committees that labored throughout the war years there was represented a greater variety of interests than was true of other program-planning groups prior to 1941. Think of the average composition of the wartime child-care committees. There we saw the social worker, the educator, the physician, the psychiatrist, the nutritionist, the clergyman, the member of C. I. O. and of A. F. of L., the representatives of local, State, and Federal agencies, the parent, the employer, the businessman, the newspaper reporter, and other citizens sitting down together with a common concern and a common purpose.

Such groups achieved amazingly good and speedy results. It is no wonder, however, that there should be some confusion in their joint thinking as to their basic responsibility. Was it to the individual child, whose mother was a defense worker? Was it to the country at war, needing workers for war industry? Or was it for protection of groups of children from neglect, introduction of preschool education to large communities, and education of parents? It was the rare child-care committee that saw its first responsibility to the individual child as a member of his family and of the community and as a future citizen. The skills represented on various committees were, as a general rule, no better unified in designing services to meet the needs of children than the skills represented on the staffs of the majority of wartime child-care centers and the presently operating day nurseries. Hence it is quite simple to understand why there have been and continue to be certain serious lacks in the programs of these facilities.

To many communities, accustomed as they are to the old concepts of need and service—that of the "underprivileged" or "inadequate" individual or group needing the help made possible by the privileged and the adequate—the apparently self-sufficient working parent with a good income and a child requiring care brought a new problem into the picture of community services. The child-care committees accepted the responsibility for local and Federal planning

Time out for milk. And the people who have charge of the day-care center know that milk helps to keep children well nourished.

for children. But some of them thought: "Surely these are adequate parents. Therefore if we care for their children, it must be with few questions asked. The reason that these parents need service is apparent. Our Nation is at war. Mothers, most regrettably, are employed in war industries and other essential occupations. Fathers are in military service."

Some educators were doubtful

Many of the educators, unaware of the difference between the professional social case worker and the depression-recruited "relief investigator," and unfamiliar with the serious problems involved in even partial separation of children from their parents and their homes, were suspicious of the suggestion that "counseling" or case-work services be included in a program of daytime care. "These parents would not use the service if it were related to welfare," they said. And they added, "Parents don't like social workers."

Under public-school administration —the auspices for the majority of these wartime day-care programs—children were admitted for care, as they are to the schools, with few questions asked.

How about fees?

It was hard, too, for the school people to charge a fee for service since this procedure was not compatible with the philosophy of free, public education. There was little more thought about sharing responsibility with parents for the care of their children in these centers than there is, usually, in sharing responsibility with parents for the process of educating their children.

Social workers encountered the same pitfall. "Our services are greatly needed in other areas," they said. "These are adequate parents. Or," they added doubtfully, "most of them are. They don't need us, at least not much. An adequate American parent is independent and can be expected to make suitable arrangements for the child, provided there are good facilities to be used. We don't know much, if anything, about nursery schools. That's the educator's job. Now, as to placement in foster-family homes by the day, we do know something about that. We'll recruit, study, and select day-care homes, even though we can ill afford the time. And in order to save time we'll put the responsibility for placement and fees right where they belong, on these adequate parents."

The doctors, too, were sore pressed; and because of the number of their colleagues absent in military service they found it difficult to carry the load of civilian patients and also to give service to groups of presumably well children. "These parents are responsible for the health of their children," the doctors said. "Most of them can see their own family physicians. Yes, group care of young children is hazardous to health, but with reasonable precautions, they'll be safe enough. And then there is the public-health nurse. Why not use her?"

The ranks of the public-health nurses were depleted by military service demands, as well. Yet in many day-care programs the only medical service available for the children in care was that of the overburdened district nurse, who came into child-care centers for health inspections and to consult with staff workers. By the time she arrived, probably a child with a sore throat, or other evidence of a communicable disease, had mingled with a number of children in the group. Children with allergies and mild cardiac disorders were often overlooked, and they continued in care undiagnosed. Many parents had no family physicians, and there was little time for clinic attendance.

These parents were for the most part adequate parents, but not adequate educators or case workers or physicians. Their need was—and is now—a service for their children, who for one reason or another required care away from home during the day; a service that reasonably should be expected to protect, preserve, and promote the health, growth, and development of each child, from the standpoint of his physical, intellectual, and emotional needs.

Service to the whole child

Although the majority of day-care programs, both group day care and family day care, fall far short of that objective, the present trend in those fields, if the work of the most progressive agencies can be considered to indicate it, is to plan, to recruit personnel, and to operate, with service to the whole child as their purpose.

Once an agency, be it a day nursery or a family day-care placement service, grasps this concept, and a few have done so, the problems of accomplishment are relatively simple.

As a day-care consultant, expected to answer at a moment's notice a variety of questions ranging from how to budget to the best way of keeping nursery floors clean, I have found it of never-failing value to respond with a question of my own. That question is simply, "What do you think will produce the best service for this child and for these children?"

It is encouraging to watch boards of directors and staffs reorganizing their services, developing and using new methods, and obtaining the necessary funds from their communities in response to that one simple question.

Plans developing

To illustrate situations where some of these new ideas are being put into effect, here are one day nursery and one family day-care agency. Some of their plans are in a state of flux; but plans there are, and much has already been accomplished.

In a midwestern industrial city there is a large day nursery, which until less than a year ago provided only fair custodial care to upward of 100 children, ranging in age from 2 to 12 years. Three years ago children under 2 years of age were also admitted for group day care, but these babies are now referred to the family day-care agency for individual placement with suitable day-care mothers. Until the early part of this year there were in addition seven child-care centers, subsidized by Lanham funds. The council of social agencies, foreseeing the serious effect upon children in the community of the sudden termination of these latter services, planned with the board and staff of the day nursery to strengthen that agency and to include under its administration the operation of from one to three of the former Lanham centers, with a grant of community-chest funds.

At present the staff of this day nursery includes an able executive director; a social worker; a bookkeeper-secretary; a physician, part time; and

group teachers and assistants, a number of whom are qualified nursery-school teachers. A young and capable ex-sergeant is employed, part time, as recreation leader for the older boys. He will serve full time during the summer months. A girls' group worker will also be employed in the near future.

Other plans are especially noteworthy and are expected to materialize within a year. These are: (1) Arrangement with a nearby university, which has a department of early-childhood education, for placement of students for practice training in the nurseries, under the supervision of the well-qualified educational director. (2) In-service training, by this educational director, of the present staff, a number of whom are not qualified except by interest in children and by personality. (3) Appointment of a fully qualified case worker, in addition to the present social worker, who has completed only a year's training. (4) Part-time leave of absence for this social worker so that she may complete her training. (5) Arrangement with the nearby school of social work for placement of one or more students for field work, under the supervision of the new case worker. (6) Appointment to the staff of a well-qualified pediatrician to replace the present physician, who is lent by the city health department. (7) Ultimate arrangement with a medical school for service from medical students as part of their pediatric experience under the supervision of the consulting pediatrician. (8) Shortening of the daily schedule for children through explaining to parents the advantages for these youngsters of their coming to the nursery an hour later each morning and returning home an hour earlier each afternoon.

Like many nurseries, this one has continued to operate from 6:30 a. m. until 6 or 6:30 p. m., 6 days a week, with no thought until recently that many parents can shift their work schedules to better advantage if they understand the needs of their children better. An eighth plan may also be made some day, to include student nurses as trainees in this program. Many nurseries have already experienced the advantages of cooperating in such a plan with local hospitals that are seeking opportunities for their student nurses to work with well children as part of their pediatric training.

Before considering the sample family day-care agency let us evaluate the foregoing factors in a good day-nursery service. First of all, the most significant indication of a new trend in the group day-care field is the fact that this community, through its council of social agencies, is recognizing the importance to children of adequate day-care service, adequate both in quality and quantity. Secondly, with this concept of service it has been able to obtain the necessary funds. And thirdly, it sees (1) the importance of a day-nursery service that combines the skills involved in pediatrics, in nursery education, in group work, and in case work; and (2) the advantage of training programs in which these professional groups cooperate. It sees also the implications for children's institutions of this training and the integration of these skills in group care of children.

The family day-care program that I wish to describe has several unique features. In the first place it is set up for the purpose of placing children in foster-family homes for daytime care and is not an appendage or department of a child-placing agency. This is important to note because experience has shown that parents are more inclined to use this type of service if it is offered by an agency organized for the purpose and is not a part of an agency with a different primary function.

The agency under consideration is incorporated, is supported by the community chest, and is recognized as a case-work agency in the community. Its recruiting, home-finding, home-study, selection, and placement procedures are comparable to those of good standard child-placing agencies. It has two pediatricians for examinations of children before placement and for periodic reexaminations.

Recognizing the importance of shar-

It's outdoor playtime at this day-care center. While the mothers of the children are at their work they can feel sure that their children are happy and are well taken care of all day long.

ing responsibility with parents for the care of their children, the agency permits the parents to have their children examined by their family physician if they prefer such an arrangement, and also permits them to pay the fees for the day-care service directly to the day-care mothers. There are regular rates for this service, and payments are adjusted to the parents' incomes on a sliding scale. This means that the agency budget carries an item for subsidy of the service in some cases, in the same manner that is customary in day nurseries.

The agency serves chiefly: (1) Children under 2 years of age, children who for physical or emotional reasons cannot benefit by group care in nurseries, (2) children whose parents' work schedules do not coincide with the day nursery schedules, and (3) children from scattered residential sections where transportation to a nursery is not feasible.

The limitations on the agency's program are: (1) Inadequate payments to day-care mothers for the children's board; (2) the usual difficulty in employing fully qualified case workers during the present-day shortage of trained social-work personnel; (3) failure to expand the service to meet the community need.

Both agencies described have done much thinking about the importance of preparing children and their parents for day-long separation, for the new experience in the group or the family day-care home, and for leaving the experience when service is terminated. Both agencies recognize the essential importance of sharing responsibility with the parent at every possible opportunity and so avoiding the common pitfall of tending to take over responsibility from the parents, which results inevitably in weakening parent-child relationships.

This question is asked repeatedly, "Under what auspices should day-care services be operated and from what sources should funds be obtained?" I offer again the answer, "Under whatever auspices or with whatever resources the child can best be served."

Part of paper given May 23, 1946, at the National Conference of Social Work, Buffalo, N. Y.

Reprints available on request

CHILDREN OF WORKING MOTHERS STILL NEED DAY CARE

Even though public day-care programs for children of working mothers no longer receive Federal assistance, many communities are making efforts to continue this service.

An example of these efforts in cities is found in Philadelphia, where continuance of 17 child-care centers was assured on June 17 through action by the city government.

Another is in Washington, D. C., where Congress has authorized the District Government to operate 14 centers until June 30, 1947.

New York City, which did not receive assistance from Lanham Act funds, as it was not a "war impact" area, is continuing to receive aid from State funds, as it did in wartime.

In New York State $2,175,000 of State money is available to aid day-care centers until April 1, 1947.

In the State of Washington the legislature has voted $500,000 to provide State assistance for 2 years.

California has enacted legislation to continue child-care centers until March 30, 1947, with a State appropriation of $3,500,000.

Massachusetts has authorized operation of child-care centers for children 3 to 13 years of age when the local school committee in a city or town decides there is need for such a program. The State may reimburse municipalities for part of the cost of the centers. There is a limitation of $15,000 annual reimbursement to any one town or city.

At the peak of the wartime child-care program, in July 1944, the program financed with Federal funds under the Lanham Act was serving nearly 130,000 children in more than 3,100 centers.

By July 1945 the enrollment had dropped considerably, but it was still nearly 102,000 and there were nearly 2,800 centers.

On February 28, 1946, the last day on which the centers received Lanham Act assistance, the number of centers, or units, was 1,479. These were located in 386 communities, in all but 2 States.

A month later, answers to questionnaires sent out by the Federal Works Agency showed that in spite of the withdrawal of Federal assistance more than three-fourths of the centers were continuing to operate. The information collected by the agency from the questionnaires is reported in the July 5 bulletin of Child Welfare Information Service (now called Social Legislation Information Service).

During the war, the bulletin reminds us, Federal funds provided two-thirds of the operating cost of the centers under the Lanham Act program. Fees made up most of the remainder, with some small contributions from States, municipalities, industry, social and civic organizations, and other groups.

After the Federal funds were withdrawn it was necessary, if centers were to be continued, to find sources of considerable funds. And a variety of sources was found.

More than half the day-care centers were in three States where State funds were available for operating them. Funds for the rest were granted by such sources as county and city governments, especially the education authorities; industry; labor unions; colleges and universities; private social agencies; public welfare departments; child-care committees or associations; churches; civic organizations; housing or tenant groups; private donations; and fees.

As for operation of the centers, public-school authorities were operating the greatest number on the date of the report, according to the Federal Works Agency. Next came child-care committees or organizations; then, private social agencies. Others operating centers included industry, private individuals, parents' and other local groups, city governments, local housing authorities, church groups, and colleges.

The report states that a very substantial gain has taken place in programs for care of children of working mothers. Before the war few if any public-school authorities were operating such programs for care of children while the mothers worked, or were providing funds for such programs. But on March 31, 1946, public schools in 176 places were operating these programs.

CHILDREN AND THE 1946 SESSION OF CONGRESS

EDITH ROCKWOOD, Office of the Chief, U. S. Children's Bureau

CHILDREN of the Nation will benefit from many of the measures passed by the Seventy-ninth Congress, which adjourned August 2, 1946. Some of these measures relate to maternal and child-health and crippled children's services, child-welfare services, aid to dependent children, insurance benefits, emergency maternity and infant care, school lunches, vocational education, citizenship of overseas children of servicemen, hospital construction, and mental health. Congress also passed measures benefiting the children of the District of Columbia; one of these provides for day-care centers for children of working mothers; another for better housing.

Expanded maternal and child-health services

Congress increased from $5,820,000 to $11,000,000 the amount authorized by the Social Security Act for annual appropriations for grants to the States (Public Law 719 approved August 10, 1946) for maternal and child-health services, administered by the Children's Bureau, and appropriated this amount for the fiscal year ending June 30, 1947 (Public Law 663 approved August 8, 1946). One-half ($5,500,000) of the amount authorized is to be allotted as follows: $35,000 for each State, and the remainder allotted to the States in the proportion that the number of live births in the States bore to the total live births in the United States for the latest calendar year for which census figures are available. These grants must be matched by State or local funds for maternal and child-health services. The other half ($5,500,000) of the amount authorized, for which matching is not required, is to be allotted to the States according to the financial need of each State for assistance in carrying out its State plan. The terms upon which the funds are to be used remain the same as in the Social Security Act of 1935, as amended in 1939.

The additional funds will permit more rapid extension and improvement of maternal and child-health services administered by State and local health departments, and are an important step toward making these services available everywhere in the country.

Emergency Maternity and Infant Care

The sum of $16,664,000 for the fiscal year ending June 30, 1947, has been appropriated for the Emergency Maternity and Infant Care program—administered by the Children's Bureau—for the wives and infants of enlisted men in the armed forces (Public Law 549 approved July 26, 1946). The reduced amount reflects the reduction in the size of the Army and Navy. The high point in this program came in the fiscal year ended June 30, 1945, when $45,000,000 was paid to State health agencies for this purpose. A million babies have been born with Uncle Sam's help since the program started, in March 1943.

Expanded services for crippled children

Congress increased from $3,870,000 to $7,500,000 the amount authorized for annual appropriation for grants to the States for services for crippled children, administered by the Children's Bureau (Public Law 719), and appropriated this amount for the fiscal year ending June 30, 1947 (Public Law 663). One-half ($3,750,000) of the amount authorized is to go to the State crippled children's agencies—$30,000 for each State and the remainder according to the need of each State after taking into consideration the number of crippled children in the State and the cost of furnishing services to them. These grants must be matched by State funds. The other half ($3,750,000) of the amount authorized, for which State matching is not required, is to be allotted to the States according to the financial need of the State for assistance in carrying out its State plan. Here also the terms upon which the funds are to be used are the same as in the Social Security Act of 1935, as amended in 1939.

The additional funds will enable the State crippled children's agencies to do a better job of locating crippled children and of providing diagnosis, treatment, and aftercare for children who are crippled or suffering from conditions that may lead to crippling. It will mean more prompt treatment for many children and expansion of certain programs such as those for children with rheumatic fever and cerebral palsy, two of the groups for whose care funds have been insufficient heretofore.

Expanded child-welfare services

Congress more than doubled the annual amount authorized for grants to State public-welfare agencies for child-welfare services, raising the authorization from $1,510,000 to $3,500,000 (Public Law 719), and appropriated this amount (Public Law 663), which is to be allotted to the States, $20,000 for each State and the remainder in the proportion that the rural population of the State bears to the total rural population of the United States. Matching by State funds is not required, but Federal funds for local child-welfare services may be used for only part of the cost of services in the local areas.

The additional funds will be used for providing for child-welfare workers in a greater number of rural areas and areas of special need, looking forward to the day when social services for children will be available in every county in the United States. Children who are homeless, dependent, neglected, or in danger of becoming delinquent will benefit from this program. The State departments of public welfare will be able to give local communities more consultation and advice in providing care and protection for children in special need and in promoting more adequate resources for their care.

For Federal administration

An appropriation of $425,000 was added to the previous appropriation for the fiscal year ending June 30, 1946, for administration by the Children's Bureau of grants to the States for maternal and child welfare, bringing this fund to a total of $902,535.

The three programs combined provide $22,000,000 for grants to the States under title V of the Social Security Act.

Children of Virgin Islands will benefit

One of the amendments to the Social Security Act provides that the Virgin Islands shall be eligible for Federal grants for maternal and child-health services, services for crippled children, and child-welfare services, beginning January 1, 1947.

Committee action

The action reported in the previous sections—increases in Federal grants to the States for maternal and child health and child-welfare services—had been recommended by the National Commission on Children in Wartime in 1945 and advocated by many national organizations. The House Committee on Labor, on July 25, reported with amendments, and recommended for passage (H. Rept. No. 2662), the bill for a "Maternal and Child-Welfare Act of 1946" (H. R. 3922). No further action was taken on the bill. The House passed another bill (H. R. 7037), which did not provide for expansion of the programs, except to extend them to the Virgin Islands.

The Senate Committee on Education and Labor held hearings in June on the "Pepper Bill" (S. 1318, companion to H. R. 3922), but decided not to attempt to complete consideration of it so late in the session. This Committee, however, recommended virtually tripling the appropriations authorized in the Social Security Act for grants to States for maternal and child-health services, services for crippled children, and child-welfare services. A joint resolution to this effect (S. J. Res. 177) was introduced by Senators Taft and Pepper on July 15, 1946, but was not acted upon. When the bill to amend the Social Security Act (H. R. 7037) came over from the House, the Senate Committee on Finance proposed, and the Senate adopted amendments in accordance with the recommendation of the Senate Committee on Education and Labor. The final amounts reported in the foregoing sections were agreed to in conference between the two Houses.

Aid to dependent children

The Federal Government can now share in higher State payments for aid to dependent children and is authorized to pay a larger proportion of the individual payments. The maximums in which the Federal Government may share are raised to $24 a month for the first child and $15 for each additional child, as compared with the previous amounts, $18 and $12. Formerly the Federal Government (within the maximums allowed) matched State payments on a 50-50 basis. Now the Federal Government may pay two-thirds of the first $9 and one-half of the balance within the specified maximum. In other words, when the State makes a payment of $24 for one child and $15 for the second—a total of $39 for two children—the Federal Government will pay $13.50 for the first child and $9 for the second—or $22.50—and the State will pay $16.50. If a State decides to let the recipients receive the greatest possible advantage from the change in the law, it will continue the amount it already is contributing to that payment. The States that are not now paying as much as the State share under the new plan, however, will need to increase their own contributions if they are to gain the full benefits for their children.

This portion of the Social Security Act is administered by the Bureau of Public Assistance, Federal Security Administration.

Mothers and children like these, in the Virgin Islands, will soon benefit through amendents to the Social Security Act.

Insurance changes benefiting children

Child survivors of veterans of World War II who die, within 3 years of discharge, "under conditions other than dishonorable" or because of disability incurred or aggravated while in service, will benefit from the provision giving to ex-servicemen the status of fully-insured workers under the old age and survivors insurance program. Persons discharged or released more than 4 years and a day after the official end of World War II will not be covered. This change was made to benefit men who had no opportunity to build up benefit rights before they entered the service, and who because they were unable to acquire social-security protection while they were in service would have no such protection for their families in case of their death.

Another set of amendments provides coverage in unemployment-insurance systems for more than 200,000 maritime workers. When these men receive payments in case of unemployment the children in their families will benefit.

Vocational education

The Vocational Education Act of 1946 (Public Law 586, approved August 1, 1946) amends the George-Deen Vocational Education Act so as to authorize an annual appropriation of

$28,500,000 instead of the $14,200,000 heretofore available for grants to States for vocational education, thereby doubling the amount formerly authorized for this purpose.

This act is administered by the Federal Board for Vocational Education.

School lunches

A permanent program of Federal aid to the States for school lunches was established by the National School Lunch Act, approved June 4, 1946 (Public Law 396). The appropriation for the fiscal year ending June 30, 1947, is $75,000,000, an increase of $17,500,000 over the appropriation for the previous fiscal year. The program is administered by the Department of Agriculture. (For additional information see the August *Child*.)

Overseas children of servicemen

To safeguard the citizenship rights of children of young servicemen who married alien wives while overseas Congress passed a law, approved July 31, 1946 (Public Law 571), amending the Nationality Act of 1940. The amended act provides that any citizen who has served honorably in World War II may transmit citizenship to his child born abroad to the citizen and an alien spouse, regardless of the fact that the citizen parent has not had the length of residence in the United States required by the previous law. This was 10 years, with at least 5 of them subsequent to the citizen's sixteenth birthday. The amended law requires, in order that the provisions regarding the child's citizenship shall apply, that the citizen parent shall have had 10 years' residence in the United States before the birth of the child, at least 5 of them later than his *twelfth* birthday.

Hospitals and health centers

More centers for child-health services and more maternity and pediatric beds in hospitals will become available through the passage of the Hospital Survey and Construction Act, approved August 13, 1946 (Public Law 725). This act authorizes a program of grants to States, including (1) $3,000,000 for State-wide surveys and planning and (2) $75,000,000 annually for 5 years for the construction of hospitals, health centers, and related facilities. Two-thirds of the cost of building and equipping such facilities must be borne by the sponsors of the individual projects—State, county, or city institutions, or private, nonprofit hospitals. The act is to be administered by the United States Public Health Service.

This construction program is basic to the development of any Nation-wide medical-care program.

While their mothers are at work, Phil, Betty, and Nan are happily occupied at a day-care center. This is one of the centers in Washington, D. C., where the District of Columbia Government is authorized to continue some centers another year.

Mental health

Children and youth will benefit also from the National Mental Health Act, approved July 3, 1946 (Public Law 487). The purpose of the act is to improve the mental health of the people through (1) conducting, assisting and fostering, and promoting the coordination of research relating to the cause, diagnosis, and treatment of psychiatric disorders; (2) training of personnel in matters related to mental health; and (3) developing, and assisting States in the use of, the most effective methods of prevention of psychiatric disorders and for the diagnosis and treatment of persons with such illness. The United States Public Health Service is to administer the act, which includes provisions for grants to the States on the basis of plans submitted by the mental-health authorities of the State. No appropriation has yet been made to carry out the act.

Day-care centers, Washington, D. C.

An act approved July 16 (Public Law 514) authorizes the Board of Public Welfare of the District of Columbia to operate from July 1, 1946 to June 30, 1947, not more than 14 nurseries and nursery schools, in public schools and other suitable locations. An appropriation of $250,000 was made for this purpose. Care is to be provided for the children of parents (1) who are employed and are financially unable otherwise to provide for the day care of their children or (2) who are so handicapped that they cannot otherwise provide such care. (Formerly day-care facilities in the District were operated by the Board of Education.) The Board of Public Welfare is authorized to fix fees to reimburse the District Government for the cost of personal services, labor, food, and supplies used for the centers, but may waive all or part of such fees if parents are unable to pay.

Housing in Washington, D. C.

Although Congress did not pass the "General Housing Act" (S. 1592) it did pass the District of Columbia Redevelopment Act of 1945 (Public Law 592 approved August 2, 1946), which will permit the replanning of blighted areas and their purchase and resale or lease by the District of Columbia for redevelopment.

This should mean eventually better housing and living conditions for many children of the Nation's capital.

Reprints available on request

SWEDEN IMPROVES SCHOOL HEALTH WORK

ANNA KALET SMITH, Office of the Chief, U. S. Children's Bureau

AMONG THE RECENT achievements in Sweden's progressive legislation is reorganization of health services for school children. Such services have been operating for about 50 years in the larger cities, but most of the small towns and the vast stretches of Sweden's forest land, with more than half of that country's population, have been overlooked. Government aid, which in Sweden is considered a requisite for the success of school health work, has been available only in some of the schools maintained by the National Government. In the schools supported by the communes—the 2,500 urban or rural districts into which the country is divided—the health work has been left to the local authorities.

Under these conditions a large number of school children were neglected, the direction of the health services lacked unity, and the information about the services was not comparable. Moreover, the school physicians were concerned mainly with treatment, while little or no attention was given to prevention.

Late in 1943 the National Board of Education, which is the official agency administering public education, proposed a plan for reorganizing public school health services. The plan was approved by the Riksdag (parliament) several months later and was put into effect, with the force of law, in the fiscal year 1945.

Under the new law school health work must be done according to uniform regulations, under the supervision of a central agency, the Office of the Chief School Physician of the National Board of Education.

The school health services are related to the health services for the general population through cooperation between the Chief School Physician and the National Medical Board, which supervises health services for the population as a whole.

The National Government contributes at least half the cost of the health services in all the schools, urban and rural. Payments are made to the district school boards, provided they fulfill certain conditions set by the law. These aim to assure health services for the largest possible number of schools. Thus, aid cannot be given to an elementary school unless all such schools in the district undertake to fulfill the conditions.

Physicians and nurses must be employed in all schools receiving Government aid. Great stress is placed on prevention of disease. To this end regular physical examinations are required, and cases of communicable disease among the pupils and their families must be reported without delay to the principal, who is to take the necessary measures in cooperation with the school physician.

Also new is a concerted effort for the early discovery of tuberculosis in the schools. Tuberculin tests are now prescribed and are given at the beginning of the school year to newly admitted children and young people and to those whose tuberculin reaction is not known. For children and young people with a negative reaction, vaccination against tuberculosis is ordered, to be followed by an annual test. Those with positive reactions are referred to X-ray clinics.

Any teacher or other school employee with a history of tuberculosis is required to report the fact to the school physician without delay. Teachers who suspect that they have tuberculosis are required to submit to an examination by the public-health physician and to report the results as soon as possible in writing to the school physician. Special measures are prescribed for teachers with active tuberculosis. Newly appointed employees of the schools other than teachers must present a physician's certificate as to the condition of their lungs.

Attention is given for the first time to mental disorders and retardation among school children throughout the country; the school physician is required to advise the principal about such cases.

A medical record of each school child and normal-school student must be kept by the physician. This record, which must be uniform in all the schools of the country, follows the child from grade to grade and from school to school. Copies of all the records are collected at the office of the National Board of Education, where data are compiled for the study of the results of the school health work.

The school physician also (1) assists in vocational guidance when this is necessary for medical reasons; (2) takes action against overwork by school children; (3) instructs the pupils in personal hygiene and at least twice each term inspects school buildings; and (4) directs and supervises the work of the school nurses.

An annual report must be submitted by the school physician to the school authorities.

The new system has brought about an increase in the school physicians' salaries, which along with their duties, are now prescribed by law, and the employment of many more school nurses than formerly; it also calls for close cooperation between the school and the parents.

Certain differences exist in application of the system to the various kinds of schools.

Elementary schools

In the rural elementary schools receiving Government aid the health work is done by the medical officer of the district. About 400 such officials are employed by the Government for the care of the population in the sparsely settled districts. In urban localities one or more special school physicians must be appointed for the elementary schools.

The question of nurses for elementary schools is solved in the following way: When the population of a district is not more than 20,000, the public-health nurse employed by the Government to

care for the general population in the district also serves as part-time school nurse, receiving no additional pay. However, appointment of full-time salaried school nurses in such districts is permitted by law. In localities with more than 20,000 inhabitants appointment of full-time school nurses is required; each such nurse may not have more than 1,500 children in her care.

Physical examinations must be given by the school physician at the beginning of every school year to children in the lowest, middle, and highest grades; also to all newly admitted children in any grade. The school authorities may order a physical examination of any child. Children seeming to be in poor health may be examined as often as the school physician considers it necessary. Parents, teachers, or school nurses may ask at any time for the examination of a child. Conditions needing attention are reported to the parents.

The duties of the school physician are defined by law. He is required to watch the children's mental and physical development and to take the necessary measures for the protection of their health and for their training in health habits. In a large school with a full-time nurse the physician must have regular office hours at the school—at least once a week.

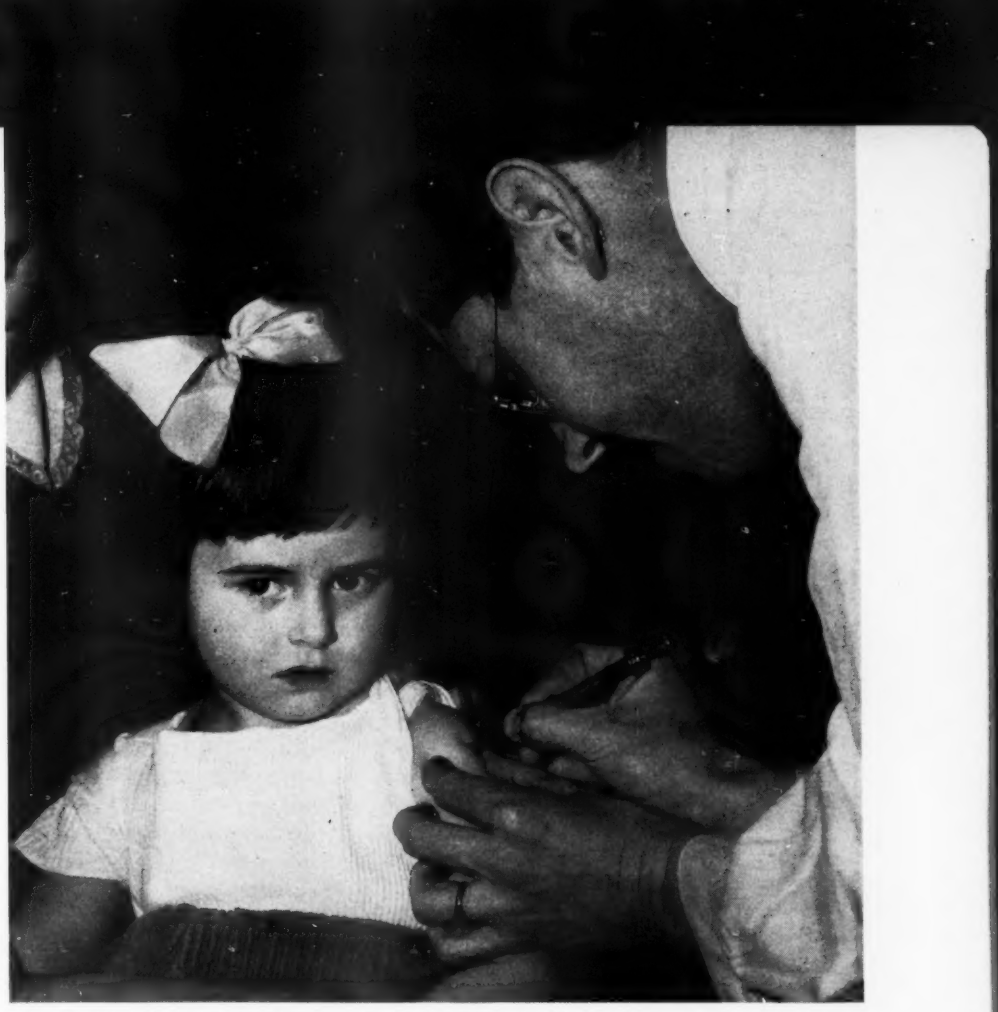
The nurses help the school physician and also visit the children's homes and advise the parents on the care of the children's health.

The teachers in the elementary schools are required to cooperate with school physicians, school nurses, and parents in measures to preserve the children's health.

Intermediate and secondary schools

Health services in the intermediate and secondary schools were briefly mentioned in the laws of 1928 and 1933. Under both laws the schools were authorized to appoint school physicians, whose duties were to be regulated by the individual schools and whose salaries were to be paid by the district school boards. This arrangement, which depended on the will of the local authorities, proved unsatisfactory. Aid from the National Government is now available to intermediate and secondary schools for the payment of half the salaries of physicians and nurses, and in some secondary schools their whole salaries. The municipalities are required to provide suitable quarters for the health services, with proper lighting, heating, and equipment. Each of the schools must have its own physician, whose duties are similar to those of the physicians in the elementary schools. In many of these schools nurses also must be employed.

A physical examination is required for each child at the time of admission and of graduation, and for all children at least every other year.



Under a new Swedish law that reorganizes school health services, stress is laid on the prevention of illness in the pupils.

Normal schools

The health services in normal schools and in the practice schools connected with them were regulated to a limited extent by the laws of 1937 and 1938. The services were expanded under the new law, and their entire cost is now borne by the National Government. Every normal school must have a physician and a nurse for the care of its students and the children in the practice school. A physical examination must be given to all normal-school students at the beginning of the school year, and to children in the practice schools at the time of admission and in the fourth and the last grades. Normal-school students may consult the physician on their own initiative. Health services for children in practice schools are similar to those for elementary-school children.

If a normal-school student or a practice-school child is absent from class for more than 6 days in succession, a report must be made to the school physician without delay.

The new system of health services for school children has been receiving favorable comments from persons interested in social improvement and is said to have brought about a "revolutionary change" in the care of school children's health in Sweden.

Sources: *Tidskrift för Barnavård och Ungdomsskydd, Stockholm, 1945, No. 1; Svensk Författningssamling, Stockholm, 1944, Nos. 584–591; 1937, No. 535; 1933, No. 345; and 1928, No. 426.*

IN THE NEWS

National conference on the control of juvenile delinquency

A National Conference on the Control of Juvenile Delinquency will be held at Washington October 21 through 23 on the invitation of Attorney General Tom C. Clark.

Federal officials, representatives of State welfare and health departments, State attorneys general, superintendents of correctional institutions, juvenile-court judges, and police and other municipal officials will be among the 800 persons attending the conference, as well as representatives of private health and welfare agencies, religious groups, youth-serving organizations, organized labor, industry, press, radio, and motion pictures. All the 48 States will be represented.

For each of the 3 days of the conference a morning, an afternoon, and an evening session is scheduled. Only the morning session of the first day will be devoted to speeches. After that the participants will be divided into about 25 panels. These panels will confer on various fields of study concerning the problems of juvenile delinquency and will make recommendations for future action for controlling it.

The scope of the panels is planned as follows: Community coordination, Training institutions, Juvenile-court legislation, Administration of juvenile courts, Detention facilities, Role of police in juvenile cases, Public and private housing programs, Child-guidance centers, Case work and group work, Recreational facilities and services, Youth participation in community and youth-service programs, Volunteer participation in community and youth-service programs, Home responsibilities, School responsibilities, Church responsibilities, Motion pictures, Press, Radio, and a special panel on Federal problems.

A preliminary panel on each subject has been formed, the members of which will be the nucleus for the panel that will meet at Washington in October. Each of these preliminary panels is now working on a draft of a report, which will be submitted to the members of the complete panel for consideration before the conference begins. When the complete panel meets it will discuss and revise the preliminary reports. The final reports will be published.

Chicago mail-order house fined $25,000 for flagrant child-labor violations

The largest fine ever imposed for violation of the child-labor provisions of the Fair Labor Standards Act of 1938—$25,000—was assessed recently by Judge John P. Barnes against a mail-order and chain-store firm in Chicago.

This establishment was first inspected by Children's Bureau representatives in 1942, and the child-labor provisions of the act were carefully explained to the persons in charge. After the inspection, at the request of officials of the firm, the Bureau at three different times sent the firm information on the child-labor provisions of the act.

Early in 1945 the Bureau received a complaint that children under 16 were employed in the establishment more than 3 hours a day on school days and after 7 p. m. in the evening, and that one of the girl workers was only 13 years old.

During the inspection made as a result of this complaint, 106 children under 16 years of age were found to have been employed contrary to the child-labor provisions of the act. Twenty-five of these children were under 14 at the time they were first employed; two were only 12. Two 14-year-olds and one 15-year-old had been employed on manufacturing operations. The other 78 children of 14 and 15 had been employed more than the maximum daily hours permitted children of their ages and had worked after 7 p. m.

Through the United States Department of Justice, criminal action was brought against the firm for willful violations of the child-labor provisions of the act. The company entered a plea of guilty, and Judge Barnes assessed the fine of $25,000.

The effect of this fine was noticed immediately; many telephone calls were received by the Chicago representative of the Children's Bureau, requesting information regarding the child-labor provisions of the act. The assessment of such a substantial fine will undoubtedly aid in obtaining compliance with these provisions of the act, not only in Chicago but throughout the country as well.

Mississippi has new youth court act

The Mississippi Legislature in 1946 passed a new juvenile-court law, known as the Youth Court Act, which includes some of the provisions sponsored by the Children's Code Commission. This repeals the existing juvenile-court law and most of the provisions of the industrial training-school act, as of October 1, 1946.

It provides for more adequate care and protection of neglected children and for the hearing of cases concerning children with behavior problems, not as criminals, but as maladjusted children in need of understanding, guidance, and rehabilitation. It also makes provisions for furnishing assistance to the court in securing an understanding of the needs of these children and more adequate facilities for meeting such needs.

It authorizes the appointment by the court, under merit-system regulations, of one or more youth counselors in each county or municipality, or jointly, or the use by the court of a youth counselor furnished by the county department of welfare, to perform any services required by the court to carry out the act.

Specific reference is made to the use of such counselors—or of the county department of welfare—for making social investigations during the preliminary inquiry which the court may make to determine whether or not it should take further action. The counselors are authorized to utilize the technical services made available through the State department of public welfare.—FREDA R. LYMAN.

FOR YOUR BOOKSHELF

STANDARDS AND RECOMMENDATIONS FOR HOSPITAL CARE OF MATERNITY PATIENTS. Children's Bureau Publication No. 314. 22 pp. Single copies free on request.

Presents hospital standards for maternity care, representing in general the consensus of present obstetric practice, along with certain recommendations that may be helpful in maintaining obstetric standards under difficult conditions.

OPEN DOORS TO CHILDREN; Extended school services. Prepared by Margaret T. Hampel and Hazel F. Gabbard. Federal Security Agency, U. S. Office of Education, Washington, 1946. 28 pp.

This well-illustrated pamphlet on activities in centers for school-age children offers helpful suggestions to teachers, supervisors, and administrators on the improvement of school services to meet the needs of children. It should help colleges and universities preparing teachers to recognize the changes they will need in curricula for future teachers and should point the way for parents and community groups to derive greater understanding of these services for children.

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"Back to School" for the boys on our September cover means not only hard study, but plenty of fun climbing in the school playground (Library of Congress photograph by Lee). Other credits: P. 51, (a), (c), and (d), Library of Congress photographs by Wolcott for FSA; (b) Pennsylvania Department of Health. P. 53 and p. 55, Library of Congress photographs by Lee for FSA. P. 58, Library of Congress photograph by Delano for FSA. P. 59, Washington Post photograph by Burruss. P. 61, Swedish Travel Information Bureau photograph by Karl Sandels.

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Honors to two excellent photographers were unintentionally misplaced in the credit lines given on photographs which appeared in the July issue of *The Child*, particularly in illustration of Miss Marion E. Hutton's article, "UNRRA Shelters Unattended Children." Herewith our apologies to the artists, and our amends: Credit for the photographs on pages 13, 15 (right), 27 (top, middle), and 28 (bottom) goes to Charles T. Haacher, New York; on pages 24, 25, 26, 27 (bottom), 28 (top, middle) to Douglas Glass, London.

MENTAL-HEALTH SERVICES

(*Continued from page 52*)

sonnel feel that they benefit in undreamed-of ways. Parents feel that they are getting something they really want.

What can health-department personnel gain from working with a psychiatrist? A few points will illustrate how the pediatrician and nurse and social worker can find ways to improve the effectiveness of the interview with the person who seeks their help. Many professional people are uneasy and impatient when a parent wants to discuss a condition that is not as concrete a topic as Johnny's or Josie's tonsils. So few know how to listen and to realize how great a part of psychotherapy this can be. We should all know more about the interplay in the emotional relationship between the giver of and the seeker for help and advice. With this knowledge we can better estimate the therapeutic importance to the patient of the interview.

More knowledge needed

We need to know more also about the various forms of adjustment that members of a growing family need to make to each other and about the failures in such adjustment that occur from time to time. We need to know a great deal more about adult psychology; more about the normal sexual behavior of adults; more about the aging processes of grandparents, which are often reflected directly upon the child in the home. We need to have more specific concepts of the simpler forms of psychotherapy—such as suggestion, authoritative direction, verbal catharsis—so that we can estimate their limitations and know better which to use.

And then we need to know more about the symptoms of mental illness—the psychoneuroses, the affective disorders such as depression and elation, the thinking disorders such as paranoia and schizophrenia, and the acute anxiety—so that a worker will know when he is in hot water and needs the help of a psychiatrist.

Gaining and using this newer knowledge will take time, for, remember, it will become a part of the physician, nurse, and social worker only as each makes an effort to learn from the patients and applies what he learns. Each worker is himself a personality, and many of his difficulties and mistakes in dealing with his patients arise from struggles within his own personality. If the worker wishes to get help in his own adjustment from the teaching of the staff psychiatrist he should be able to get it. This process is really a form of emotional growth of the worker—and sound growth is slow.

Help from consultants

One way that might help in attaining this emotional growth is to have the health-service worker spend 3 to 6 months on the staff of a mental-hygiene or child-guidance clinic. However, this is not entirely practical. Only a few workers could be accommodated because there are only a few such clinics. Also, mental-hygiene clinics are so overworked that there is little time for extra supervision and instruction. Probably a more profitable way would be to have a mental-health consultant attached to each health department. The sole duties of this consultant would be staff training and consultation. This plan is now being considered by several States. Provided such a consulting service is on a constant and long-time basis, consultants could also be loaned the health departments from the staffs of mental-hygiene clinics.

More of these ventures have to be undertaken by health and welfare departments. The people of this country want this mental-health aspect of medical practice, which the legitimate professions offering to serve them have in a large part not been able to give them. Because the public has not been able to get this help in clinics and in doctors' offices, many people have sought a poor substitute in the parlors of the fortune-tellers, palm readers, and other cultists.

Public-health departments then should plan for this additional service to their patients. As a result, the public-health worker will gain satisfaction from his patient's sense of being well cared for. He will also get the pleasant self-esteem that comes from knowing that as a professional worker he is growing in his job.

Reprints available on request

ANOTHER STEP FORWARD

Congress has taken another step forward to conserve the Nation's children. It has virtually doubled the Federal funds available to the States for services to children under the maternal and child-welfare provisions of the Social Security Act.

It is now 11 years since the Seventy-fourth Congress passed the Social Security Act. This act authorized appropriation of $8,150,000 annually to help the States build up their maternal and child-health services, services for crippled children, and child-welfare services. In 1939 Congress increased this authorization to $11,200,000.

These grants helped greatly. But the funds had to spread so thin that the services have been inadequate. And large numbers of children who need services have had to go without them.

Many counties are still without maternity clinics, well-child centers, school-health services, and the like; some do not even have a public-health nursing service. Last year 20,000 crippled children were on State lists to receive care but could not get it.

Mothers—200,000 of them a year—are having their babies without a doctor in attendance; thousands get no medical attention before the baby's birth. Children are growing up with little or no supervision of their health and virtually no medical care.

The needs of socially handicapped children are as great as those of the physically handicapped. Children in jail, orphans, runaways, children in homes where there is marital discord, children with early behavior problems—these are only a few of the types of children that need child-welfare services. Yet five out of six counties have no full-time child-welfare worker paid from public funds.

Realizing the great needs that still exist, the Seventy-ninth Congress has increased the sum available annually to the States for these needs to $22,000,000.

With Federal funds virtually doubled, and with each State's own funds also, the States hope to care for additional thousands of mothers and children each year. Also to reach many crippled children who could not be reached before and to help them grow up happy and self-supporting. And to serve a larger proportion of children who are homeless, dependent, or neglected or in danger of becoming delinquent.

New groups of physically handicapped children will be included in many State programs. More children with rheumatic fever and heart disease will be cared for. Programs for children with cerebral palsy will be developed, as States and communities organize the services of doctors, nurses, physical therapists, and others to make up the teams of workers required for a good program. More children with hearing and vision defects will receive care.

Some States will pay special attention to health services for preschool or school-age children—preventive, diagnostic, and treatment services. Programs to care for prematurely born infants will be high on the priority list.

Child-welfare services will be available to more children as the States can engage more full-time workers. And these workers will give better service as the States can provide graduate training in recognized schools of social work. More counties will get regular help from child-welfare consultants.

All the States are ready to begin expanding their children's services. And they will continue to lay stress on improving these services in rural areas.

The Children's Bureau, as in the past, will approve State plans and will be the Federal agency through which the States receive the grants.

The new funds will not enable the States to do the whole job. Far from it. But all the States now have the chance to build—on the foundation they have laid in the past decade—more of the well-rounded services that some day must be within reach of every child.

Martha M. Eliot

MARTHA M. ELIOT, M. D.,
Associate Chief, Children's Bureau.

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CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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